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Developmental History

Please complete the following questionnaire to give me a general understanding of your child's developmental history.

Child's name: _____ Birth date: _____Age:_____
Name of the parent/guardian: _____
Home Address: _____
City: _____ State:_____ Zip Code:_____ Today's date:_____
Home Phone: ( ) ____- _____Cell Phone: ( ) ____- _____ e-mail:_____
Emergency Contact's name: _____ Phone: ( ) ____- _____
Person completing this form: _____Relationship to child: _____
Child's Birthplace: _____

What are your primary concerns for your child?

_____
_____
_____
_____

Who referred you to me? _____

Family History:

1. Child is living with:
   □ Both parents □ Mother □ Father □ Grandparent(s)
   □ Mother & Stepfather □ Father & Stepmother □ Legal Guardian
   □ Other: _____

2. Is the child adopted:
   □ Yes □ No Child's age at adoption: _____

3. Status of parents' marriage:
   □ Married □ Separated □ Divorced □ Widowed □ Single
   How long married? _____ How long divorced? _____ Child's age at divorce: ____

4. Father's Name: _____ Age:_____ Education: _____
   Employed: _____ Work phone: _____
   Type of work: _____

5. Mother's Name: _____ Age:_____ Education: _____
   Employed: _____ Work phone: _____
   Type of work: _____

6. List the people who live at home:

Name:	Age:	Relationship to child:	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Please provide any information about your child's immediate/extended family that might help us understand the child's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

_____
_____
_____

Educational History:

Current grade: _____ Name of School: _____
Phone Number: _____
Teacher's Name: _____
Type of school: □ Public □ Private □ Special
How does the school describe your child's classroom behavior?_____
_____
_____

What does your child do best at school?_____
_____

Is he/she involved in extracurricular activities? Please list_____

Do you feel your child is learning up to his or her potential? □ Yes □ No
If no, please indicate the academics areas that are underdeveloped:

□ Mathematics: □ Problems with acquisition of mathematical facts □ Careless errors
□ Difficulty performing simple arithmetic (e.g., addition, subtraction, division)
□ Difficulty understanding word-problems □ Other: _____

□ Reading: □ Difficulty matching letter sounds to written symbols
□ Difficulty pronouncing words (especially long ones)
□ Reading is "choppy" or non-fluent
□ Difficulty with reading comprehension □ Other: _____

□ Writing: □ Poor pencil grip □ Letters too big □ Inconsistent spacing / inconsistent handwriting
□ Difficulty expressing ideas in writing □ Poor spelling

□ Language: □ Difficulty finding words to name objects □ Takes a long time to get a thought across
□ Difficulties understanding or following directions even when paying attention
□ Other: _____

Please check any other concerns or problem your child has in school:

□ Does not do homework	□ Excessive time to complete assignments	□ Distracted
□ Poor handwriting	□ Forgets assignments	□ Test Anxiety
□ Does not remain seated	□ Starts but does not finish homework	□ Noncompliant in class
□ Incomplete classroom work	□ Excessive talking	□ Fails to check homework
□ Messy/disorganized	□ Poor attention in class	□ Makes careless errors

Has your child been retained a grade? □ Yes □ No. If yes, which grade? _____
Did your child attend preschool or daycare? □ Yes □ No
Were there any early concerns regarding learning or behavior? □ Yes □ No
Has the child been placed in special education programs currently or in the past? □ Yes □ No

Does your child have:
1. Learning disability (LD): □ Yes □ No. Subjects:_____
2. Language disorder: □ Yes □ No. Type: _____
3. Tutoring: □ Yes □ No. Where: □ School □ Other: _____
Is you child receiving special education/ 504 / Other Health Impaired (OHI) services? □ Yes □ No

Birth and Developmental History:

Pregnancy:

Length of pregnancy: _____ Illness or complications while pregnant? □ Yes □ No
If yes, please explain: _____
Medications used **during** the pregnancy: _____
Substances used **during** the pregnancy:
□ Cigarettes How many? ___ How often? (day/week): _____
□ Alcohol How many drinks? ____ How often?(day/week/month):_____
□ Drugs Please describe type and frequency of use: _____

Labor and Delivery:

Was your child's birth normal? □ Yes □ No
Were there any concerns at birth related to lack of oxygen (e.g., born "blue"?): □ Yes □ No

Perinatal History:

Birth weight: _____ Length: _____
Did mother or baby stay in Special or Intensive Care? □ Yes □ No
Please describe any problems: _____

Infancy and Early Childhood:

Please rate your child as an infant on the following behaviors. Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	□ Tantrums □ head-banging
Cautious and careful	1	2	3	4	5	□ Accident Prone □ Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with other people

Please list any other problems or comments regarding infancy or early childhood development: _____
_____
_____
_____
_____

Please list (in months) the ages your child met these developmental milestones:
Sat on own: _____ Stood up holding onto furniture: _____ Walked alone: _____

Any concerns with your child's *gross* motor development (e.g., running, skipping, jumping): ___
_____

Fed self with spoon: _____ scribbled: _____ tied shoes: _____

Any concerns with your child's *fine* motor development (e.g., writing, buttoning, zipping): ____
_____

Used single words: _____ Used 2+ word-sentences: _____ described a thought: _____

Any speech hearing or language difficulties? □ Yes □ No

Has your child received speech therapy? □ Yes □ No

Potty trained/day: _____ Potty trained/night: _____

Overall rate of development: □ Slow □ Normal □ Fast

Medical History:
Pediatrician's Name: _____ Phone Number: _____

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? □ Yes □ No
If yes, please describe condition/injury, treatment, any surgery, how long, and where.
_____
_____
_____
If the child had a head injury: Did s/he lose consciousness? □ Yes □ No How long? _____

Has your child been diagnosed with a chronic health condition? □ Yes □ No
If yes, please describe: _____

Does your child take any medication on a regular basis? □ Yes □ No
If yes, please list the name and dosage: _____

Behavioral and Mental Health History:
1. Please describe any behaviors that are particularly concerning to you or others: _____
_____
_____
_____

2. Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child' age at the time, and comments. _____
_____
_____

3. Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? □ Yes □ No
If yes, please give the name of previous therapist: _____
May I contact this provider? □ Yes □ No. If yes, please provide phone number: _____

4. Has the child received previous educational or neuropsychological testing? □ Yes □ No
If yes, please list the month and year in which testing was completed:
_____

5. Please circle all traits that apply to the child **NOW**:

sad	Happy	leader	follower	moody	friendly
overactive	independent	dependent	sensitive	affectionate	fearful
cooperative	tantrums	lethargic	loner	sleep problems	misbehaves
quiet	defiant	even-tempered		difficult to discipline	

6. Interactions with peers: □ No friends □ Few Friends □ Loses friends
□ Trouble making new friends □ Mean, aggressive □ Too shy or too timid
□ Bossy, controlling □ Risky behaviors

Has your child experienced any of the following:
□ Being teased or bullied □ Teasing/bullying others □ Peer rejection □ Popularity with peers

7. Has your child or any of your family members struggled with any of the following problems? Place checkmark in all that apply:

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries						
Panic Attacks						
Obsessions/Compulsions						
Tics: vocal / motor						
Headaches						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADHD						
Problems with anger						
Problems with Assertiveness						
Opposition or Defiance						
Problems with the Law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use						
Eating Disorder						
Abuse/Neglect						
Other						

Please list any other areas of concern or information you feel I need to know in the area below: